Department of Veterans Affairs **VHA DIRECTIVE 2005-024**
Veterans Health Administration
Washington, DC 20420 **June 8, 2005**

POLYTRAUMA REHABILITATION CENTERS

1. PURPOSE: This Veterans Health Administration (VHA) Directive defines the policy for the Polytrauma Rehabilitation Centers (PRC). ***NOTE:*** *The Secretary of Veterans Affairs has designated four VA Medical Centers with co-located TBI Lead Rehabilitation Centers as PRCs. They are Richmond, VA; Tampa, FL; Minneapolis, MN; and Palo Alto, CA.*

2. BACKGROUND

a. Recent combat has resulted in new patterns of polytraumatic injuries and disability requiring specialized intensive rehabilitation processes and coordination of care throughout the course of recovery and rehabilitation. While serving in Operations Iraqi and Enduring Freedom, military service members are sustaining multiple severe injuries as a result of explosions and blasts. Improvised explosive devices, blasts, landmines and fragments account for 65 percent of combat injuries. Congress recognized this newly emerging pattern of military injuries with the passage of Public Law 108-422, Section 302, and Public Law108-447.

b. Of these injured military personnel, 60-62 percent have some degree of traumatic brain injury (TBI). Operating under a national Memorandum of Agreement with the Department of Defense (DOD), the four current Department of Veterans Affairs (VA) TBI Lead Rehabilitation Centers have provided rehabilitation care to the majority of the severely combat injured personnel requiring inpatient rehabilitation. Consequently, they have developed the necessary expertise to provide the coordinated interdisciplinary care required. This experience has demonstrated that treatment of brain injury sequelae needs to occur before or in conjunction with rehabilitation of other disabling conditions.

c. Recognizing the specialized clinical care needs of polytrauma patients, VA has established four Polytrauma Rehabilitation Centers (PRCs). The mission of the PRCs is to provide comprehensive inpatient rehabilitation services for individuals with complex cognitive, physical and mental health sequelae of severe and disabling trauma and provide support to their families. Intensive clinical and social work case management services are essential to coordinate the complex components of care for polytrauma patients and their families. Coordination of rehabilitation services must occur seamlessly as the patient moves from acute hospitalization through acute rehabilitation and ultimately back to his or her home community.

d. **Definitions**

(1) **Blast Injury.** Blast injuries are a result of exposure to the violent force from an explosion. They result in a wide, but somewhat predictable, pattern of injuries. Detailed discussion of blast injuries can be found at http://www.bt.cdc.gov/masstrauma/explosions.asp.)

THIS VHA DIRECTIVE EXPIRES APRIL 30, 2010

(2) **Polytrauma.** For the purposes of this Directive, polytrauma is defined as injury to the brain in addition to other body parts or systems resulting in physical, cognitive, psychological, or psychosocial impairments and functional disability. Injury to the brain is the impairment, which guides the course of the rehabilitation. TBI frequently occurs in polytrauma and in combination with other disabling conditions such as amputation, auditory and visual impairments, spinal cord injury (SCI), post-traumatic stress disorder (PTSD), and other mental health conditions.

(3) **Polytrauma Rehabilitation Center (PRC).** A PRC provides comprehensive interdisciplinary rehabilitation and coordinates complex medical, surgical, and mental health care, as well as long-term follow-up.

(4) **PRC Medical Director.** The PRC Medical Director is a board-certified or board-eligible Physical Medicine and Rehabilitation (PM&R) physician or a board-certified or board-eligible physician in another medical specialty with at least two years of experience in rehabilitation of brain injury, amputation and other complex impairments.

(5) **Admission and Follow-up Clinical Case Management.** The clinical case managers provide clinical case management of referrals and follow-up for the ongoing rehabilitation plan of care after discharge. Individuals assigned to this function require knowledge and clinical reasoning skills necessary to review the medical status of the patient, identify all of the current medical problems, evaluate the acuity level, assess factors surrounding readiness for inpatient rehabilitation, and monitor patient status until transfer is completed. The clinical case manager makes recommendations for alternative care settings when appropriate. The clinical case manager organizes the rehabilitation health care services that promote optimal outcomes for patients. This includes assessing patients' strengths, challenges, prognosis, functional status, goals, and needs for specific services and resources, and developing a plan that identifies short- and long-term goals. Additional responsibilities may include coordinating resources to implement the plan and evaluation of the effectiveness and appropriateness of the services provided throughout the entire spectrum of care. Following discharge from the PRC, the clinical case manager proactively follows the patient to:

(a) Monitor medical, functional, and psychosocial problems;

(b) Coordinate the ongoing rehabilitation plan of care and services;

(c) Advocate for the patient and family; and

(d) Assess clinical outcomes and satisfaction.

NOTE: *A Certified Rehabilitation Registered Nurse (CRRN) possesses the critical clinical expertise and the knowledge of rehabilitation to best perform these functions. Other disciplines, such as a nurse practitioner or physician assistant with experience in rehabilitation, may be considered.*

(6) **Social Work Case Management.** In collaboration with the clinical case management described in subparagraph 2d(5), the PRCs must provide social work case management services

for all patients and their families. VHA Directive 2005-017, Social Work Case Management in Polytrauma Centers, provides additional guidance on the provision of these case management services. Social work case management differs from clinical case management in that the social worker case manager addresses the psychosocial needs of the patient, advocates for the patient and family, provides supportive services for the family and caregivers, and addresses home and community environment issues. A social worker case manager conducts a comprehensive psychosocial assessment, which includes review of cultural issues, patient support systems, family and caregiver support systems, financial and vocational status, and the living situation. In partnership with the clinical case manager, patient, and family, the social worker case manager develops treatment and discharge plans and provides ongoing case management services including post-discharge. The social worker case manager may provide clinical services, such as individual and family counseling and grief counseling. The social worker case manager contacts the patient or family prior to transfer to answer questions they may have and to assist with the transition. Social worker case management services continue through the rehabilitation process and post-discharge, providing assistance with transitions to the referring military treatment facility (MTF) or other VHA facility, or to the home and community.

3. POLICY: It is VHA policy that the PRCs provide a full-range of care for all patients eligible for VA care, who have sustained varied patterns of severe and disabling injuries including TBI, amputation, visual and hearing impairment, SCI, musculoskeletal injuries, wounds, and psychological trauma.

4. ACTION

a. Each PRC must maintain a number of beds appropriate to current and anticipated workload that includes those beds assigned to the co-located TBI Lead Rehabilitation Center. Additional beds may be required based on capacity demands.

b. Dedicated rehabilitation staff (see Attachment A) with expertise in treating major conditions associated with polytrauma serve as the core interdisciplinary rehabilitation team. A Physical Medicine & Rehabilitation Service (PM&RS) physician must be available 24 hours a day, 7 days a week for clinical care. Other consultative specialists identified as having the necessary expertise in complications and sequelae of polytrauma (see Att. B) consult and follow closely with the core team, depending upon the individual needs of the patient. Each PRC is expected to maintain accreditation by the Rehabilitation Accreditation Commission (CARF) in comprehensive inpatient medical rehabilitation and brain injury rehabilitation.

c. Medical centers designated as PRCs are expected to admit polytrauma patients who may have a high degree of medical complexity and acuity. Therefore, prior to transfer, all appropriate medical and surgical specialty services must be consulted to ensure that the patient is admitted to the bed service able to provide the appropriate level of care. If hard copy medical records or documentation are insufficient to determine medical stability or patient care needs, the best qualified staff physician at the accepting PRC must discuss the case personally with the physician providing care at the MTF. In addition, consultative services by staff physicians (see Att. B) must be available 24 hours a day, 7 days a week to respond to urgent requests or emergent needs for service.

d. Polytrauma patients with a dual diagnosis of SCI and TBI must be screened prior to admission in consultation with the SCI Service Chief to determine the most appropriate admitting facility.

e. **Under Secretary for Health.** The Under Secretary for Health is responsible for approving any proposed changes to the PRCs including, but not limited to, changes in mission, staffing, bed level, reduction of clinical services, reorganization, and changes in clinical staff.

f. **Chief Officer, Patient Care Services.** The Chief Officer for Patient Care Services has overall responsibility for the contents of this VHA Directive.

g. **Chief Consultant, Rehabilitation Strategic Healthcare Group (SHG).** The Chief Consultant, Rehabilitation SHG, is responsible for:

(1) Providing national program leadership for PRCs; and

(2) Reviewing proposed program changes with the Chief Patient Care Services Officer (11), Deputy Under Secretary for Health (10A), Deputy Under Secretary for Health for Operations and Management (10N), and other relevant program offices and staff, then forwarding recommendations to the Under Secretary for Health.

h. **PM&RS National Program Office.** The PM&RS National Program Office is responsible for:

(1) Identifying the scope of services necessary to provide optimal care to this unique patient group;

(2) Establishing an effective service delivery model;

(3) Providing referral and clinical care guidance;

(4) Monitoring the PRCs with regard to capacity, clinical care outcomes, and costs;

(5) Ensuring that each PRC undertakes service level quality improvement activities that monitor critical aspects of care, including CARF accreditation in comprehensive integrated inpatient rehabilitation and comprehensive inpatient brain injury rehabilitation;

(6) Representing VHA on matters concerning polytrauma rehabilitation; and

(7) Reviewing and recommending approval of new programs.

i. **Seamless Transition Office.** The Seamless Transition Office serves as a liaison between MTFs and the PRCs to facilitate the transition of the combat-injured service members. The Office of Seamless Transition is responsible for:

(1) Facilitating communications between the MTF, the PRC, and the injured service member and family;

(2) Facilitating exchange of medical records between the MTF and the PRC;

(3) Facilitating transition of care from the MTF to the PRC, including obtaining TRICARE authorization for reimbursement for treatment; and

(4) Facilitating transition of care from the PRC to the next level of care.

j. **Veterans Integrated Service Networks (VISNs).** VISNs provide a critical juncture in implementation and support of the four PRCs to allow timely and full access to consistent, quality care that is integrated and coordinated within the larger VHA system of care. VISN offices are responsible for facilitating access and integration with other VISNs for care and services as these patients transition to VHA care closer to their home.

k. **VISNs 6, 8, 21 and 23.** VISNs 6, 8, 21 and 23 are also responsible for:

(1) Providing the necessary resources and support to those medical centers designated as PRCs to ensure that they have capacity to provide the full spectrum of services that may be required to care for patients with polytrauma;

(2) Ensuring any proposed changes to the PRCs are appropriately reviewed and approved by the Deputy Under Secretary for Health for Operations and Management (10N), Chief Patient Care Services Officer (11), Rehabilitation SHG Chief Consultant (117C), National Program Director, PM&RS (117), and Deputy Under Secretary for Health (10A) before forwarding to the Under Secretary for Health for approval; and

(3) Providing the necessary educational support to those medical centers designated as PRCs to ensure that the clinical providers obtain and maintain the necessary knowledge and skills to provide state-of-the-art medical care and rehabilitation.

l. **Medical Center Director.** Each Medical Center Director is responsible for ensuring that:

(1) All polytrauma patients are initially referred to the VA Polytrauma Center or SCI Center in their respective referral region.

(2) Polytrauma patients with a dual diagnosis of SCI and TBI are screened prior to admission in consultation with the local SCI Chief, or designee, to determine admission to a polytrauma center (for SCI and severe TBI) or SCI Center (for SCI and mild to moderate TBI).

(3) Each VHA facility's Polytrauma Admissions Clinical Case Manager or SCI Chief, as applicable, facilitates screening and provides recommendations as to the most appropriate level of care.

m. **Medical Center Director at each of the Four Facilities with a PRC.** The respective medical center Director at each of the four facilities with a PRC is responsible for:

(1) Facilitating transfers of care between MTFs and the PRC;

(2) Ensuring that medical center leadership is a visible participant in the admission and hospital stay, recognizing the importance of the service these individuals have provided to their country;

(3) Meeting environmental and staffing requirements for the PRC, to include:

(a) Polytrauma beds which must be located contiguously in a designated unit with appropriate safety features such as alarm systems and specialized beds, etc.;

(b) Accredited prosthetic and orthotic laboratory;

(c) Specialized treatment areas to include quiet treatment areas, age appropriate recreation areas, and access to general physical therapy, occupational therapy and speech language therapy areas;

(d) Polytrauma unit designed to meet all accommodations for handicap accessibility; and

(e) Dedicated space provided for family rest and relaxation.

(4) Provision is made for patients with polytrauma to have basic medical and primary care, and emergent medical and surgical care; and

(5) Facilitating access to the next appropriate level of care, e.g., transition of care back to the MTF, or transition of care to the VHA facility closest to the service member's home with the capability of meeting care needs.

n. **Chief of Staff (COS) at each of the Four Facilities with a PRC.** The COS at each of the Four Facilities with a PRC is responsible for:

(1) Ensuring availability of a PM&RS staff physician 24 hours a day, 7 days a week;

(2) Establishing local policy to ensure that a multidisciplinary assessment is performed immediately upon admission and an interdisciplinary treatment plan is documented. Medical and surgical specialty services (e.g., physical medicine and rehabilitation, surgery, psychiatry, medicine, orthopedics, infectious disease, etc.) are to be involved in the pre-admission assessment of patients with polytrauma.

(3) Ensuring rapid availability of dedicated consultative services (see Att. B) to respond to urgent and emergent requests.

(4) Ensuring that non-emergent consultations are completed within 48 hours. Each medical center with a PRC must provide a consultation timeliness report to the PM&RS National Program Office on the fifth business day of each month.

(5) Ensuring that results and recommendations of multidisciplinary evaluations and interdisciplinary treatment are documented in the patient's medical record. The medical center's Quality Management Section must conduct weekly prospective audits of the documentation of patients with polytrauma. ***NOTE:*** *Variances must be corrected immediately.*

(6) Establishing local policy to address instances when the acuity level of the patient may dictate admission to a bed service other than the Polytrauma Rehabilitation Unit.

(7) Maintaining the core interdisciplinary staffing levels within the guidelines (see Att. A). Each facility may increase staff as required by local needs. The medical center must provide a core staffing report to the PM&RS National Program Office on the fifth business day of each month.

(8) Ensuring that patients and their families receive all necessary support services to minimize stress during the hospital stay. Supports need to include, at a minimum, psychosocial support and social work case management services and necessary physical support services, such as: lodging, transportation, meals, incidentals, etc.

(9) Ensuring that representatives from Chaplain Service and Readjustment Counseling Service are available to patients and families soon after admission and as needed.

(10) Consulting the PM&RS National Director for any variances in the recommended clinical care model for the PRCs.

(11) Ensuring that staff assigned to the PRC receives the training necessary to provide state of the art care for patients with polytrauma.

o. **Chief Nurse Executive at each of the Four Facilities with a PRC.** The Chief Nurse Executive (CNE) at each of the Four Facilities with a PRC is responsible for:

(1) Ensuring availability of nursing and other assigned program services 24 hours a day, 7 days a week.

(2) Ensuring rapid availability of dedicated consultative services (see Att. B) under the CNE's authority to respond to urgent and emergent requests.

(3) Ensuring that non-emergent consultations for assigned services are completed within 48 hours. The CNE must coordinate with the COS the monthly reporting of consultation timeliness under the CNE's responsibility to the PM&RS National Program Office on the fifth business day of each month.

(4) Collaborating with the COS to ensure that results and recommendations of multidisciplinary evaluations and interdisciplinary treatment are documented in the patient's medical record.

(5) Maintaining the nursing and other assigned program staffing levels within the guidelines (Attachment A). Each facility may increase staff as required by local needs.

(6) Consulting the PM&RS National Director for any variances in the recommended clinical care or staffing models as they impact the CNE's program responsibilities for the PRC.

(7) Ensuring that all staff within the CNE's responsibility assigned to the PRC receives the training necessary to provide state of the art care for patients with polytrauma.

p. **PRC Medical Director.** The PRC Medical Director, or staff physician designee, is responsible for:

(1) Screening all referrals to the PRC and ensuring that all appropriate medical and surgical services are consulted and the admission plan is consistent with the medical acuity and needs of the patient.

(2) Initiating a physician-to-physician call between the PRC and the appropriate MTF in the event that necessary medical records or information are not available for review.

(3) Admitting eligible individuals with polytrauma consistent with the mission, scope of services, diagnostic etiologies, and medical and functional requirements of patients.

(4) Providing comprehensive interdisciplinary care consistent with standard operating procedures for the PRC.

(5) Maintaining ongoing and frequent communications between the MTF and the PRC.

(6) Ensuring adequate communication between facilities whenever a transfer of care occurs.

(7) Ensuring that an appropriate discharge plan is communicated to all relevant entities, e.g., DOD, Seamless Transition Office, receiving MTF or VHA facility, patient and family, and that the plan is implemented. Proactive long-term clinical and social work case management services will be provided until the discharge plan is fully implemented and all additional identified needs have been addressed.

(8) Ensuring that outcomes of all patients with polytrauma are tracked and monitored in the PM&RS national Functional Status and Outcomes Database.

(9) Managing service level quality improvement activities that monitor critical aspects of care. An ongoing and continuous evaluation of the program must be conducted to ensure the quality and appropriateness of care provided to patients.

5. REFERENCES

a. Public Law 108-422 (Section 302), Centers for Research, Education, and Clinical Activities on Complex Multi-trauma Associated with Combat Injuries.

b. Public Law 108-447, Prosthetics and Integrative Health Care Initiative.

c. Memorandum of Understanding, the Department of Veterans Affairs and the Rehabilitation Accreditation Commission (CARF), February 1, 2002.

d. VHA Directive 2005-017, Social Work Case Management in Polytrauma Centers.

e. MP-1, Part 1, Chapter 13, Section III, Conditions Under Which Transfers are Authorized.

f. M-1, Part 1, Chapter 25, Beneficiary Travel.

g. Memorandum of Agreement (MoA) between VA and DoD on Referral of Active Duty Military Personnel Who Sustain Spinal Cord Injury, Traumatic Brain Injury, or Blindness to Veterans Affairs Facilities for Health Care and Rehabilitative Services, 2004.

h. Peake, JB. "Beyond the Purple Heart - Continuity of Care for the Wounded in Iraq," New England Journal of Medicine. 352(3):219-222; January 20, 2005.

i. The Defense and Veterans Brain Injury Center (see http://www.dvbic.org/).

6. FOLLOW-UP RESPONSIBILITIES: The Chief Patient Care Services Officer has overall responsibility for the contents of this Directive. Questions may be addressed to 804-675-5597.

7. RESCISSIONS: None. This VHA Directive expires April 30, 2010.

S/ Jonathan B. Perlin, MD, PhD, MSHA, FACP
Under Secretary for Health

DISTRIBUTION: CO: E-mailed 6/9/2005
FLD: VISN, MA, DO, OC, OCRO, and 200 – E-mailed 6/9/2005

ATTACHMENT A

CORE DEDICATED STAFFING PER SIX BEDS FOR EACH POLYTRAUMA REHABILITATION CENTER

PERSONNEL DESCRIPTION	Full-time Equivalent (FTE)
Rehabilitation Physician	.5
Registered Nurse (2.0 must be Certified Rehabilitation Registered Nurse (CRRN))	6.0*****
Licensed Practical Nurse and/or Certified Nursing Assistant	4.0*
Nurse Manager	.5
Admission and Follow-up Clinical Case Manager	.5
Social Worker or Case Manager	1.0******
Speech-Language Pathologist	1.0
Physical Therapist	1.0
Occupational Therapist	1.0
Recreation Therapist	.5
Counseling Psychologist	.5
Neuropsychologist	.5

***** Based on a national survey of nursing hours of care reported by rehabilitation bed units.
****** Per Directive 2005-017, Social Work Case Management in VHA Polytrauma Centers

ATTACHMENT B

DEDICATED CONSULTATIVE SERVICES RECOMMENDED AT EACH MEDICAL CENTER WITH A POLYTRAUMA REHABILITATION CENTER

Audiology
Blind Rehabilitation Outpatient Specialist
Certified Orthotist
Certified Prosthetist
Clinical Nutrition
Clinical Pharmacy
Dentistry and/or Oral and Maxillofacial Surgery
Driver Training
Ear, Nose, and Throat (ENT)
Gastroenterology
General Medicine
General Surgery
Infectious Disease
Neurology
Neuroophthalmology
Neurosurgery
*****Optometry
Orthopedic Surgery
Plastic Surgery
Psychiatry
Post-traumatic Stress Disorder (PTSD) Clinic Team
Pulmonary
Radiology
Urology
Vocational Rehabilitation

***** If not available on site, services may be obtained on a contractual basis.